Lower GI Part I 2023
Q&A
May 4, 2023

	Question	Answer
1.	Comment: also seen physicians refer to Houston's valves to describe tumor location in rectum	That is correct: The valves of Houston are located in the rectum and these transverse folds of circular muscle help support the fecal material within the rectum. Most people have 3, but there may be any number from 2 to 4.
2.	If you have a LAMN that isn't stated to be "malignant" but on the path report it says it's invading the subserosa or serosa, can we assign a /3?	For a 2022+ diagnosis, this would be categorized as a T3 tumor (subserosa) or T4a (serosa), and would be considered malignant. https://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging-8th-edition/lower-gastrointestinal-tract-chapters-19-21/appendix-carcinoma-chapter-19/136140-incidental-finding-of-lamn-pt4a
3.	Are there any thoughts from standard setters about more definitions for the macroscopic eval of mesorectum data item or an additional item to code location in the rectum (mid/low/high)? Currently for the related CoC std 5.7 we have to manually review for whether rectal case needs to be included depending on location (mid/low/high).	Sounds like a good suggestion, but we do not have such a proposal at this point. I suggest sending this question into the CAnswer forum. CoC would need to make the proposal for a change.
4.	Poll 5: Should it had stated 36 months instead of 35 months later due to the rules being 3 years?	In the scenario for this Poll question, the time frame didn't matter because the case still met the criteria for M7, "Abstract multiple primaries when a subsequent tumor arises at the anastomotic site AND: one tumor is NOS and the other is a subtype/variant of that NOS **OR** the subsequent tumor occurs greater than 36 months after the original **OR** the subsequent tumor arises in the mucosa. The first tumor in 2020 was adenocarcinoma, NOS and the recurrence (even though 35 months later) was mucinous adenocarcinoma (subtype of adenocarcinoma). The tumor only has to meet ONE of the criterial in M7 to apply the rule.

5.	How do you code histology when a path report Final Dx states a difference from Histologic Type in the Synoptic Report?	Code from the one with the most specific histology. Usually, that will be the synoptic.
6.	What is the difference then between 8140 and 8255?	8140 is adenocarcinoma NOS while 8255 is mixed subtypes adenocarcinoma.
7.	A 2021 LAMN with mets to lungs is not reportable? Slide #36 statement ... spread or met not reportable. Are they not referring to the intraperitoneal mets?	This statement is per SEER Sinq 20230007. This post specifically addresses metastatic mucinous neoplasm involving lung parenchyma and pleura. If the word "neoplasm" had been replaced with "carcinoma" to report LAMN prior to 2022.
8.	With the example case in SINQ20230007, if the case were diagnosed in 2022, would the behavior code be /3 with the lung mets?	No, the behavior would not be /3 because the lung mets were LAMN, not carcinoma or adenocarcinoma.
9.	We do not usually have a statement of malignancy of the LAMN and HAMN in the path report. So we would stop at Rule H5 and code to /2, would not move on to Rule H6. Based on H5, most of our LAMN/HAMN cases were coded to /2. We submitted a coding question to SEER Inquiry who indicated we should look at the extent of the disease, code /3 if the LAMN invade beyond muscularis propria, which can be classified as T3 or T4 respectively. There was also a post from Canswer Forum, it also indicated that we can code the LAMN to /3 if there is involvement of the subserosa or the serosal surface, T3 or T4. It looks like SEER and AJCC have agreement on this but STR doesn't have this coding instruction. If a HAMN or LAMN is malignant, what should we be looking for? Can we use the stage info to code behavior for LAMN or HAMN?	For a 2022+ diagnosis, this would be categorized as a T3 tumor (subserosa) or T4a (serosa), and would be considered malignant. https://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging-8th-edition/lower-gastrointestinal-tract-chapters-19-21/appendix-carcinoma-chapter-19/136140-incidental-finding-of-lamn-pt4a The tumor cannot be /2 and be a T3 or T4.

10.	Reference for poll #7: page 13 of the STM (March 2023 update), the clarification statement has been in previous versions of the STM.	That's correct. It's not new, but it is often missed.
11.	What if outside pathology consult differs? Does that take priority for coding histology/grade/extent of disease?	SEER Program Coding and Staging manual **s**tates, "SEER recommends that information from consult pathology reports be preferred over the original pathology report. This is because consults are usually requested from a more experienced or specialized pathologist/lab and are generally thought to be more accurate. " A similar statement can be found on page 21 of the Grade manual, page 18 of the SSDI manual. For coding histology, the Solid Tumor Rules General instructions (page 13) states "For each site, priorities include tissue/histology, cytology, radiography/scans, and physician diagnoses, and biomarkers. You must use the priority order that precedes the histology rules for each site." Extent of Disease includes all the clinical and pathological findings in the medical documentation.Page 15 in the EOD general instructions, states, "However, in the event of a discrepancy between pathology and operative reports concerning excised tissue, priority is given to the path report".
12.	Does the STM have a statement about what to do if the pathologist's final diagnosis differs from the synoptic report? I know we take the most specific histology from questions posted/answered - but wasn't sure if a clarifying statement is in the STM.	Yes. Please refer to the STR General Instructions on page 13: **Which document to use when there is conflicting information between the final diagnosis, synoptic report, or CAP protocol:** When there are discrepancies between the final diagnosis and synoptic report, use the document that provides the more specific histology. This will likely be found in the synoptic report. The CAP Protocol should be used only when a final diagnosis or synoptic report are not available. Definitions for CAP Protocol, final diagnosis, and synoptic report can be found in the Definitions section.
13.	For poll #10, even though the polypectomy is a surgery, because the intent was diagnostic rather than definitive treatment, is that the reason why you would have a clinical grade in that situation?	Not all surgical procedures are treatment; ex. TURBT is a surgical code but it does not meet the criteria for pathological classification in the bladder chapter of AJCC. We are to follow the AJCC guidelines of clinical and pathological criteria to determine whether it is considered clinical grade or pathological grade.

14.	For poll #13, if there was residual on the resection then the excisional bx would be clinical timeframe for grade?	This is according to the Grade manual: Grade Clinical For the Grade Clinical data item, record the grade of a solid primary tumor before any treatment. Treatment may include surgical resection, systemic therapy, radiation therapy, or neoadjuvant therapy. All surgical procedures are not treatment, e.g. TURB and endoscopic biopsies. For the Grade Pathological data item, record the grade of a solid primary tumor that has been surgically resected and for which no neoadjuvant therapy was administered. If AJCC pathological staging is being assigned, the tumor must have met the surgical resection requirements in the AJCC manual. This may include the grade from the clinical workup, as all information from diagnosis (clinical staging) through the surgical resection is used for pathological staging.
15.	For the CRM SSDI, I have seen, on occasion, that the synoptic reports does NOT include the CRM, but the CRM is noted down in the gross section of the pathology report. Per question and answer from CAForum it is acceptable to use the size of the CRM from the gross section if that is all you have.	Thanks for that tidbit! And that is correct. The information for the CRM can come from anywhere in the pathology report or from a physician statement when no other information is available. There is nothing in the SSDI that says the CRM has to come from the synoptic report.
16.	How do you code the CRM when the path report does not give a distance from any of the margins? Just says the margins are free.	According to the coding guidelines you would Code XX.1 when the CRM margin is stated as clear, but the distance is not available.
17.	Poll 20 - I thought we could not code the CRM if all that is documented is "All margins negative"?	That is correct. That poll was based on a CAnswer Forum post which was answered incorrectly. The response has now been corrected. https://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/gi-schemas/137435-colorectal-ssdi-circumferential-radial-margin-visceral-peritoneum
18.	What were the answers for 19 and 22 please?	19 was 10.1 greater than 1 cm and 22 was 20.1 at least 2 cm
19.	The coding guidelines for CRM state " codes xx.3-xx.6 is for when the pathology uses "atleast" categories... so why was the correct answer for the poll 20.1? Can someone point me in the	Those at least codes are for 1 mm, 2 mm, and 3 mm; This was 2 cm (20 mm), so those codes are not appropriate.

	direction of the general guidelines where I would find the answer for round to 20.1 when its atleast 20?	
20.	Clarification- there is no mismatch in the repair proteins. Mismatch refers to the mismatched pairing of the proteins are either expressed or not.	We did not say there was mismatch repair in the proteins. Slides 85 and 86 are demonstrating whether the MMR proteins are expressed or not.
21.	Poll 20, margins NOS not used to code CRM. Do not agree with answer of clear, no size stated.	That is correct. That poll was based on a CAnswer Forum post which was answered incorrectly. The response has now been corrected. https://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/gi-schemas/137435-colorectal-ssdi-circumferential-radial-margin-visceral-peritoneum
22.	For LAMN/HAMN, if you stage anything greater than a 0 for Seer Summary Stage, you get an edit for LAMN/HAMN behavior code /2, which to me implies it would be /3 behavior code.	You should not be assigning a Summary Stage 0 for LAMN/HAMN that are invasive.
23.	Should we be assigning MiNEN morphology code 8154/3 for the mixed neuroendocrine/ adeno or continue to assign 8244/3 MANEC	This is why we follow the instructions in the STR. Code MiNEN to 8154 This is from Table 1. Mixed neuroendocrine nonneuroendocrine neoplasm 8154. MANEC is listed as a synonym for mixed adenoneuroendocrine carcinoma 8244. "In 2017, the WHO renamed MANECs from the pancreas as "mixed neuroendocrine non-neuroendocrine neoplasms" (MiNENs), where the 30% threshold for each component was maintained, but the term "exocrine" was substituted by the more general term "non-neuroendocrine" to include histological variants that cannot be referred to as exocrine (e.g., squamous or sarcomatoid phenotypes), and the term "carcinoma" was substituted by the term "neoplasm" to recognise the fact that occasionally, one or both components are low-grade malignant [5]. Very recently, the WHO has extended the use of the term to all neoplasms meeting the diagnostic criteria for MiNENs arising from any site within the GEP tract [6]. Compared to "MANECs", the term "MiNENs" is believed to better address the heterogeneous spectrum of possible combinations between neuroendocrine and non-neuroendocrine elements and the variability of morphologies, which are largely determined by the site of origin [2]."

		https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7019410/#:~:text=Compared%20to%20%E2%80%9CMANECs%E2%80%9D%2C%20the,site%20of%20origin%20%5B2%5D.
24.	When a physician does a colonoscopy and can see a tumor can we automatically assume this is arising in the mucosa without further documentation of cancer arising outside the bowel wall.	We would need to use all information available to decide whether this is a metastatic tumor invading into the mucosa from the wall or a tumor arising in the mucosa.
25.	Where did you find the hierarchy for which diagnostic imaging is more specific for diagnosis?	That is in the Colon STR under item 3 in the section that starts with: This is a hierarchical list of source documentation. Code the most specific pathology/tissue from either resection or biopsy. Note 1: The term "most specific" usually refers to a subtype/variant. Note 2: The histology rules instruct to code the invasive histology when there are in situ and invasive components in a single tumor. Note 3: When there is a discrepancy between the biopsy and resection (two distinctly different histologies/different rows), code the histology from the most representative specimen (the greater amount of tumor). 3. Scan: The following list is in priority order. A. CT B. PET C. MRI
26.	Can you explain the difference between combined small cell carcinoma 8045 (synonym small cell carcinoma mixed with adenocarcinoma) AND Mixed adenoneuroendocrine 8244 (synonym Adenoca. with mixed high grade small cell EC)	We need to use the terms used in the pathology report. If the diagnosis is small cell carcinoma NOS mixed with adenocarcinoma, neuroendocrine carcinoma, or any other type of carcinoma/adenocarcinoma, we assign 8045 combined small cell carcinoma. If you have a diagnosis of MANEC, assign 8244.
27.	Sometimes path reports mention margin distance from the mesenteric root. How, if at all, does this fit into this CRM SSDI?	The root is the part of the mesentery that is connected with the structures in front of the vertebral column. The root of mesentery crosses the second and third parts of duodenum, abdominal aorta, Inferior vena cava, right ureter, right psoas major muscle, and right gonadal artery. This would be a good question to submit to the SSDI forum.

28.	The handouts do not include your explanations to the poll answers, will they be added?	I am not sure since they are provided in the recording. We normally do not have a separate handout for the polls. Since they are provided in the recording. This may be something discussed.
29.	The wording "at least" is coded the same way as "greater than" in the CRM SSDI?	Yes. This will be addressed in the 2024 updates to the SSDI. https://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/gi-schemas/136481-crm-at-least
30.	How do we apply something that's not published until 2024?	We are not required to use the guidance that is not published in the manual; however, if we know about the guidance, we should use it.